DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 1 4

2. STATE: OKLAHOMA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
08/01/00

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.170(g)
42 CFR 440.10 & 1905(a) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 2,284,971
b. FFY 2001 $ 11,448,961

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attached

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attached

10. SUBJECT OF AMENDMENT:
Annual payment adjustment for inpatient hospital services and adding critical access hospital services.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Michael Fogarty

14. TITLE: Chief Executive Officer

15. DATE SUBMITTED: 9-28-00

16. RETURN TO:
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, OK 73105

Attn: Billie Wright

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2000

18. DATE APPROVED: June 6, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: August 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: for Calvin G. Cline

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

RESCINDED

23. REMARKS:

c: Michael Fogarty
Billie Wright
Jim Hancock

FORM HCFA-179 (07-92)

Instructions on Back

Attachment to HCFA-179 Transmittal Number: 0 0 – 1 4

Section 8. Page Number of the Plan Section or Attachment	**Section 9**. Page Number of the Superseded Plan Section or Attachment *(if applicable)*	
Attachment 3.1-A, Page 9	Revised 10/11/93	TN#93-20
Attachment 3.1-B, Page 9	Revised 10/11/93	TN#93-20
Attachment 3.1-A, Page 10	New Page	
Attachment 3.1-B, Pages 9a-3	New Page	
Attachment 4.19-A, Page 3	Revised 07/01/98	TN 98-18
Attachment 4.19-A, Page 3.1	Revised 07/01/98	TN 98-18
Attachment 4.19-A, Page 5	Revised 07/01/98	TN 98-18
Attachment 4.19-A, Page 5.1	Revised 07/01/98	TN 98-18
Attachment 4.19-A, Page 17b	Revised 07/01/98	TN 98-18
Attachment 4.19-B, Page 35a	New Page	

State/Territory: OKLAHOMA

AMOUNT, DURATION , AND SCOPE OF MEDICA AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the secretary.

a. Transportation.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanitoria.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided

d. Nursing facility services for patients under 21 years of age.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.
☐ Provided ☐ No limitations ☐ With limitations*
☒ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not provided.

g. Birthing Center Services.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not provided.

h. Critical Access Hospital.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not Provided.

*Description on attachment

State/Territory: OKLAHOMA

AMOUNT, DURATION , AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):_____

24. Any other medical care and any other type of remedial care recognized under State law, specified by the secretary.

a. Transportation.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanitoria.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided

d. Nursing facility services for patients under 21 years of age.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.
☐ Provided ☐ No limitations ☐ With limitations*
☒ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not provided.

g. Birthing Center Services.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not provided.

h. Critical Access Hospital.
☒ Provided ☐ No limitations ☒ With limitations*
☐ Not Provided.

*Description on attachment

State: OKLAHOMA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

24.h. **Critical Access Hospital**

Acute care hospitals that qualify as Critical Access Hospitals (CAHs) will receive a payment adjustment to the prospective per diem rates. CAHs are rural public or non-profit hospitals which provide 24 hour emergency care services, are limited to 15 inpatient beds (can have 10 additional swing beds) and inpatient stays are limited to 96 hours. In order to qualify for the payment adjustment, a hospital must be designated as a CAH by the Oklahoma State Department of Health.

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State: OKLAHOMA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Groups

24.h. **Critical Access Hospital**

Acute care hospitals that qualify as Critical Access Hospitals (CAHs) will receive a payment adjustment to the prospective per diem rates. CAHs are rural public or non-profit hospitals which provide 24 hour emergency care services, are limited to 15 inpatient beds (can have 10 additional swing beds) and inpatient stays are limited to 96 hours. In order to qualify for the payment adjustment, a hospital must be designated as a CAH by the Oklahoma State Department of Health.

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METHODS AND STANDARDS OF REIMBURSEMENT
FOR INPATIENT HOSPITAL SERVICES

The only two exceptions to this logic are for payment for claims in Level 7 and for payment for routine inpatient surgical procedures. Payment for claims classified into Level 7 will be made at two level of care rates when a claim has both ICU/CCU revenue code charges and routine revenue code charges. When this occurs, payment is split between Levels 7 and 8. Claims for a single stay shall not be split and submitted as two claims solely for the purpose of obtaining two different level of care payment rates (except when patients receiving psychiatric care in acute care hospitals are transferred to medical units because their non-psychiatric medical needs become the primary cause of hospitalization). There are two restrictions on these levels of care:

1. Only Level III neonatal units will be paid the NICU level of care per diem rate. For rate setting purposes a hospital is considered eligible to receive the Level III NICU rate if it meets the criteria used by the Health Planning Commission (now part of the Oklahoma Department of Health) in its 1988 Hospital Utilization and Plan Survey.
2. All claims from free-standing inpatient psychiatric hospitals will be paid at the Level 6, Psychiatric, level of care rate. (Psychiatric claims from acute care hospitals will also be paid at the Level 6 rate).

Payment rates for Level 7 (ICU/CCU) and Level 8 (Routine) are peer grouped based on hospital teaching and nonteaching status. For payment purposes, hospitals that either (1) belong to the Council on Teaching Hospitals, or (2) have a medical school affiliation qualify for the teaching peer grouped rate for Levels 7 and 8. All other hospitals receive the nonteaching rate for Levels 7 and 8.

The second exception provides for payment of specified routine inpatient surgical procedures at the routine care per diem rate instead of the surgical care per diem rate. This exception is effective for services provided on or after May 1, 1994.

These level of care rates are calculated from 1988 claims and uniform cost report data from each provider's fiscal year ending in calendar 1988. Costs were inflated to a common point of time prior to calculation of the median cost per day.

Level of care per diem rates are inflated annually effective July 1 of each year using the lesser of the available Data Resources, Inc. (DRI) PPS-type Hospital Marketbasket Index's forecast for the midpoint of the upcoming state fiscal year or the latest Health Care Financing Administration (HCFA) proposed update factor for non-PPS (exempt) hospitals published in the Federal Register or in federal legislation, whichever is later, prior to the start of the state fiscal year. Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year solely as a result of later available forecasts or actual inflationary changes.

Effective July 1, 1998 rates will no longer be updated annually according to the DRI methodology above. Effective July 1, 1998 rates will be updated using the prior year level of care per diem multiplied by an update factor. The update factor will be determined by multiplying the DRI fourth quarter index's forecast for the midpoint of the state fiscal year (2.4% for SFY 99) by the HCFA PPS-type Hospital Marketbasket weight assigned for compensation (61.39% for SFY 99). A state plan amendment will be submitted to update future rate periods.

Effective August 1, 2000 rates for Levels 1, 2, 4, 5, 6, 7 & 8 will be updated using the prior year level of care per diem multiplied by an update factor as specified in House Bill 2019 of the 47th Legislature. The update factor for Levels 1, 4, 5, 6, 7 & 8 is 12%. The update factor for Level 2 is 20%. An adjustment of $55.50 is added to the prior year Level 3 per diem. A state plan amendment will be submitted to update future rate periods.

METHODS AND STANDARDS OF REIMBURSEMENT
FOR INPATIENT HOSPITAL SERVICES

For services on or after February 1, 1993 through June 30, 1993, hospitals with allowable costs above the statewide median level of care will be limited to reimbursement of the statewide median level of care rate, except for levels 7 and 8, which will not exceed the peer group median. When a hospital's allowable costs are less than the statewide median level of care, 62.5 percent of the difference will be added to the hospital's specific facility level of care rate. Beginning July 1, 1993, the add-on to the facility specific level of care rate will be 25 percent of the difference between the statewide median level of care rate (except levels 7 and 8) and the hospital's specific level of care rate.

Hospital-specific costs per day within each level of care were calculated using the following steps:

a. Claims were categorized into levels of care.
b. Using uniform cost report information for the corresponding time period, charges submitted on the claims were converted to costs using facility-specific cost-to-charge ratios (fixed capital and direct medical education costs were removed at this time.)
c. All costs were inflated to a uniform point in time (the midpoint of the state's payment year.)
d. Peer grouping analyses were performed to evaluate statistically significant differences in costs across categories of hospitals (e.g., teaching versus nonteaching).
e. Facility-specific costs per day were calculated for each level of care category.

These hospital-specific rates are calculated from 1988 claims and uniform cost report data from each provider's fiscal year ending in calendar 1988. Costs were inflated to a common point of time prior to calculation of the facility specific costs per day.

Facility-specific per diem rates are inflated annually effective July 1 of each year using the first quarter publication of the Data Resources, Inc. (DRI) PPS-type Hospital Marketbasket Index's forecast for the midpoint of the upcoming state fiscal year, prior to the start of the state fiscal year.

Effective July 1, 1998 rates will no longer be updated annually according to the DRI methodology above. Effective July 1, 1998 rates will be updated using the prior year level of care per diem multiplied by an update factor. The update factor will be determined by multiplying the DRI fourth quarter index's forecast for the midpoint of the state fiscal year (2.4% for SFY 99) by the HCFA PPS-type Hospital Marketbasket weight assigned for compensation (61.39% for SFY 99). A state plan amendment will be submitted to update future rate periods.

Effective August 1, 2000 rates for Levels 1, 2, 4, 5, 6, 7 & 8 will be updated using the prior year level of care per diem multiplied by an update factor as specified in House Bill 2019 of the 47th Legislature. The update factor for Levels 1, 4, 5, 6, 7 & 8 is 12%. The update factor for Level 2 is 20%. An adjustment of $55.50 is added to the prior year Level 3 per diem. Effective August 1, 2000 Critical Access Hospitals (CAHs) will be reimbursed according to the methodology described in Attachment 4.19-B, page 35a. A state plan amendment will be submitted to update future rate periods.

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TN # 00-14 Approval Date 06-06-01 Effective Date 08-01-00

Supersedes
TN # 98-18

Step 2. The sum of each level of care offered within a category will be divided by the number of patient levels of care offered within a category to arrive at an average per diem for each category.

Step 3. A value factor each patient level of care within a category will be determined by dividing the operating (level of care) prospective rate for each level of care by the average operating (level of care) prospective rate for each category.

Step 4. The value factor (from Step 3) will be multiplied by the statewide median capital per diem to arrive at the weighted fixed capital per diem reimbursement rate.

3. Adjustments. The statewide median per diem capital amount is calculated from 1989 uniform cost report data from each fiscal year ending in calendar 1989. Costs were inflated to a common point in time prior to the calculation of the median cost per day. The statewide fixed capital per diem average of all free-standing psychiatric hospitals and the statewide fixed capital per diem median of all inpatient hospitals are annually inflated effective July 1 of each year by the latest one year District Comparative Cost Multiplier for the Central Region, Class A Construction, in the January edition of the Marshall Valuation Services, published by Marshall & Swift. Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year using later available forecasts or actual inflationary changes. Effective July 1, 1998, no annual adjustment will be applied to the statewide fixed capital per diem average of all free-standing psychiatric hospitals and the statewide fixed capital per diem median of all inpatient hospitals. Effective August 1, 2000, the statewide fixed capital per diem average of all free-standing psychiatric hospitals and the statewide fixed capital per diem median of all inpatient hospitals will be updated using the prior year per diem multiplied by an update factor of 12%.

New in-state hospital providers (this does not include hospitals having a change of ownership) lacking 12 months of cost report information shall receive the statewide capital per diem amount. After submittal of the first full year's cost report, capital payments will be in accordance with the methodology described above.

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METHODS AND STANDARDS OF REIMBURSEMENT
FOR INPATIENT HOSPITAL SERVICES

Direct Medical Education Per Diem – The third rate component, a hospital-specific direct medical education per diem, is paid to those hospitals with allowable direct medical education costs as defined in HCFA publication 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. New hospitals must have 12 full months of cost report data in order to receive a hospital-specific direct medical education per diem. Effective July 1, 1998, direct medical education per diem rates will be updated by multiplying the prior year medical education per diem rate by the update factor described on Page 3. For purposes of this amendment, effective August 1, 2000, direct medical education per diem rates will be updated by multiplying the prior year medical education per diem rate by an update factor of 7.5%.

A cost variance adjustment factor (CVAF) as described on page 4, or a fraction thereof, will be applied prospectively to the inflated direct medical education per diems prior to the start of the State fiscal year when:

1. the reimbursement system changes from statewide or peer group medians to facility-specific per diems and the variance is greater than 1.5% at the 50th percentile; or,

2. at least 25% of the in-state facilities have filed a rate appeal in the immediately preceding fiscal year and the variance is greater than 1.5% at the 50th percentile.

B. **Out-of-State Hospitals**

Hospitals, for which the department has on file a fiscal year 1989 or more recent full year cost report, are reimbursed the same as in-state Oklahoma hospitals.

Hospitals, for which the Department does not have a fiscal year 1989 or more recent cost report on file, will also receive the level of care per diem rates. However, capital and direct medical education rate components will not be reimbursed on a hospital-specific basis. Instead, these hospitals shall receive the statewide median capital per diem amount. The statewide median direct medical education per diem rate will be paid to qualifying hospitals.

In the absence of substantiating information verifying eligibility for the teaching hospital peer group, an out-of-state hospital will be presumed to be a non-teaching hospital and will be paid at the non-teaching rate for levels 7 and 8. A retroactive adjustment will be made for the difference in the teaching/non-teaching rates if eligibility is subsequently determined for services provided on or after the effective date of eligibility.

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METHODS AND STANDARDS OF REIMBURSEMENT
FOR INPATIENT HOSPITAL SERVICES

Federal and State Hospitals, including Veteran's Administration Indian Health Service/Tribal Facilities and Oklahoma Department of Mental Health facilities are not eligible for supplemental DME payments under this section. Major teaching hospitals, as defined in 4.19-A, page 17, Part F, are eligible.

3. **Determination of the Count of Eligible Resident FTE.** The resident must be assigned to a specific hospital for a supervised hospital-based experience. Required residency, clinical or educational experience will be allowed. Rotations that are primarily clinical, even though involving some hospital training are not counted as resident-months. Training outside the formal residency program (moonlighting and overtime) is not eligible for this payment.

4. **Reporting Requirements.** Determination of a hospital's eligibility for a DME supplemental payment adjustment will be done quarterly by the OHCA based on reports designed by the OHCA. The reports will detail the resident-months of support provided by the hospital and be attested to by the hospital's administrator or designated personnel and by the residency program director. The hospitals, at a minimum, will report the residents' name, Social Security #, hours worked, total assigned resident-months for the quarter and department of assignment. The reports will be subject to audit and payments will be recouped for inaccurate or false data. The reported resident-months will also be periodically compared to the annual budgets of three schools, the annual HCFA form 2552 (Cost Report) and the monthly assignment schedules prepared by the schools.

5. **Allocation of Funds.** An annual fixed DME payment pool will be established based on the state matching contribution being made available for this purpose by other state agency sources. The payments will be distributed based on the number of resident-months at each participating hospital. For payment purposes, the number of resident-months will be weighted by factor of 2.0 towards Public/Private Major Teaching Hospitals. The pool of available funds will be paid out by quarter and will be Allocated to the hospitals based on the prior quarter's reported resident-months, weighted as described above. Formula: Total payment = [(Total Annual Pool/4) / weighted* resident-months] times, (X), resident-months for the quarter. * The resident-months for Public/Private Major Teaching facilities weighted at 2.0 and all others at 1.0.

6. **Upper Payment Limit.** If payment in G (5) causes total payments to exceed. Medicare upper limits as required by CFR 447.272, the amount of payments over the limit will be recouped based on the total resident-months for that fiscal year. The upper payment limits will be determined in advance of the fiscal year from a compilation of the total allowable costs for all hospitals reported on the latest available HCFA 2552 cost reports compared to the reimbursement (including spend-down, TPL & co-payments for the same periods as reported through the State MMIS.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Critical Access Hospitals

Effective August 1, 2000 acute care hospitals that qualify as Critical Access Hospitals (CAHs) will receive a payment adjustment to the prospective per diem rates. CAHs are rural public or non-profit hospitals which provide 24 hour emergency care services, are limited to 15 inpatient beds (can have 10 additional swing beds) and inpatient stays are limited to 96 hours. In order to qualify for the payment adjustment, a hospital must be designated as a CAH by the Oklahoma State Department of Health.

The payment adjustment will be determined using the hospital specific level of care per diem rates in effect on July 31, 2000 and updating by a factor of 38%.

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